KDHE Program Visit Form - Infant/Child/Adolescent

Which Child was involved (Client Name):

_____

Date of Activity:_____/_____/_____

Agency/Clinic:_____

Client Address: _____

City:_____**Zip Code:** _____

County of Residence: _____

Phone No:_____-_____- _____

Email: _____

Preferred Method of Contact: (check all that apply)

- ☐ Phone call
- ☐ Text
- ☐ Email
- ☐ Mail
- ☐ Do Not Contact

Program: (select one)

- ☐ Maternal Child Health (MCH/M&I)

Primary Healthcare Coverage: (select one)

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP (Formerly HealthWave)
- ☐ Medicare (client is on disability)
- ☐ Unknown/Not Reported

Secondary Healthcare Coverage: (select one)

- ☐ None
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP (Formerly HealthWave)
- ☐ Medicare (client is on disability)
- ☐ Unknown/Not Reported

Has the client had a well visit during the last 12 months? (With any provider, not just within the program)

- ◯ Yes
- ◯ No
- ◯ Client is unsure

Does the Child have a Medical Home?

- ☐ Yes
- ☐ No

Does the client have a special health care need or disability? (Has a medical diagnosis or requires care beyond general preventive care)

- ☐ Yes
- ☐ No

Household Size: (number of people) _____

Annual Household Income: $_____

Annual Household Income: (select range)

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $19,999
- ☐ $20,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 or more
- ☐ Don't Know
- ☐ Refused

Visit In-Person or Virtual?

- ☐ In person
- ☐ Virtual, phone call only
- ☐ Virtual, video chat (Skype, Zoom, FaceTime, etc.)